

Health Regulation & Licensing Administration

Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
600 North Capitol St., N.E.  
Washington, D.C. 20002

PRINTED: 06/24/2011  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CORRECTIONS A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS  A licensure survey was conducted on June 22, 2011. A sampling of three residents was selected from a residential population of five men with various degrees of intellectual and/or developmental disabilities.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE  Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.  This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to ensure blinds were in good repair for one of three residents in the sample. (Resident #2)  The findings include:  An environmental walk-through was conducted on June 22, 2011 at approximately 3:00 p.m. and revealed one of the blinds in Resident #2's bedroom as well as a blind near the kitchen door were broken. In an interview with the House Manager (HM) on June 22, 2011 at approximately 3:02 p.m. it was acknowledged the blinds in Resident #2's bedroom and in the kitchen were broken.  There was no evidence all of the blinds in the facility are kept in good repair.	I 022	1022- Facility Managers Complete a facility checklist weekly to ensure safe, clean, orderly and attractive appearance of each facility. This checklist is reviewed by the QDDP weekly and monitored monthly by the Program Director. Once a maintenance need is identified on the weekly checklist it is reported to maintenance. If it is a safety or health risk it is addressed immediately otherwise it is completed within 72 hours. Upon completion it is inspected by the QDDP and the maintenance form is signed by both. Additionally the blinds were replaced.	7-15-11
I 072	3503.3(a) BEDROOMS AND BATHROOMS  Each bedroom shall be equipped with at least the following items for each resident:	I 072		

Health Regulation & Licensing Administration

*Michael Warren*

TITLE

Program Director

(X6) DATE

7-8-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

VIC911

If continuation sheet 1 of 9

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 072	Continued From page 1  (a) Standard single or twin-sized bed;  This Statute is not met as evidenced by: Based on observation, the facility failed to provide bed mattress suitable to meet the needs of one of three residents in the sample. ( Resident #5)  The finding includes:  On June 22, 20021, a approximately 2:55 p.m., the mattress on Resident #5's bed was observed to be sunken, concave in the center and appeared to not be able to provide adequate support. In an interview with the House Manager (HM) on June 22, 2011 at approximately 2:57 p.m. it was acknowledged Resident #5's mattress was sunken, concave in the center and would not provide adequate support.  There was no evidence the bed mattress was suitable to meet the needs of the resident.	I 072	See 1022. Additionally mattress was replaced	7-15-11
I 090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner.  The findings include:	I 090	See 1022. Additionally maintenance has addressed the following:	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 2  Observations on the environmental walk-thru and interview with the House Manager (HM) on June 22, 2011, beginning at 2:55 p.m., revealed the following:  Basement interior:  1. The back of the dryer was covered in lint and there were several large balls of lint on the floor behind the dryer. The exhaust hose attached to the back of the dryer was covered in lint, lying on the floor with one end connected to a large broken lint filled plastic box sitting on the basement floor. Interview with the Maintenance Director on June 22, 2011 at approximately 3:15 pm revealed the large broken plastic box was an internal "lint trap" designed for homes that did not have dryer vents leading to the outside of the house.  [ Note: On June 22, 2011 at approximately 3:30 p.m., the Fire Inspector for the District of Columbia Fire Department (DCFD) was made aware of the facility's dryer exhaust system and stated that the DCFD would consider the incident as a compliant and conduct an inspection of the facility on June 23, 2011. On June 22, 2011 at approximately 4:00 p.m., The Program Manager was informed of the aforementioned concerns by the Department of Health/ Health Regulation Licensing Administrator (DOH/HRLA) and advised to discontinue using the dryer until it was approved by the DCFD]  2. The ceiling four (4) light fixtures in the basement had missing globes;  Interior:	I 090	i090 continued.  1. Dryer vent exhaust is constructed to exhaust on the exterior of the facility  2. Basement lights were installed with covering (globes).  <u>Interior.</u>	7-8-11          7-8-11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 090	Continued From page 3  1. The carpet on the second and third floor hallways was soiled, buckling and loose;  <b>2</b> The wooden hand rail leading to the third floor was loose;  <b>3</b> The cable wire was loose and detached from the wall on the second floor;  4. The unlocked third floor storage rooms which are assessable to the residents in the facility contained the following items:  a. Cardboard boxes of resident files on the floor; b. Office records in piles on the floor and c. Ex-Large plastic tubs sitting on the floor  Exterior  1. The wooden hand rail was splintered; and  2. Chipped paint was observed on the outside walls of the house.  In an interview with the House Manager on June 22, 2011 at approximately 4:10 p.m., it was acknowledged the above-cited deficiencies were present at the time of the survey.	I 090	<i>Interior continued.</i>  1. Carpet repaired  2. Hand rail secured.  3. Cable wire secured.  4. Third floor storage door lock repaired and stored items at least six inches off the floor.  <i>Exterior</i>  1. Hand rail replaced.  2. Outside walls painted	7-18-11 7-8-11 7-8-11 7-8-11       7-15-11 7-18-11	
I 379	<b>3519.10 EMERGENCIES</b>  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be	I 379			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 379	<p>Continued From page 4</p> <p>followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the Group Home for Persons with Individual Disabilities (GHPID) failed to ensure unusual incidents that interfered substantially with the resident's health was reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for one of the three residents included in the sample. (Resident #1 )</p> <p>The finding includes:</p> <p>A review of the facility's incident reports on June 22, 2011, beginning at approximately 8:00 a.m. revealed no documented evidence of any unusual incidents in the facility. Review of Resident #1's medical consult dated May 9, 2011, at approximately 10:55 a.m. on June 22, 2011, revealed the resident was evaluated and had been treated with Neosporin Ointment for bedbug bites in the primary care physician's (PCP's) office. Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and House Manager on June 22, 2011, at approximately 11:00 a.m. revealed the facility was exterminated for bedbugs on May 14, 2011. Review of the ReMedy Pest &amp; Termite Control Service Ticket on June 22, 2011, beginning at approximately 1:00 p.m. confirmed the above. In an interview with the Incident Management Coordinator on June 22, 2011, at approximately 2:30 p.m. it was acknowledged the Department of Health, Health Regulations and Licensing Administration</p>	I 379	<p>Upon review of the records 7-8-11 it was indicated that staff reported the presents of bugs, the nursing dept. provided evaluation of individuals and follow up care per the PCP, maintenance ensured that the facility was treated to prevent further bites. The QDDP however did not follow up with reporting the incident and proper notification. The QDDP has been removed for poor work quality. We will continue to provide ongoing training and support to our staff to comply with all emergency reporting requirements.</p>		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 379	Continued From page 5  Division (DOH/HRLA )was not notified of this incident.  At the time of the survey, the GHPID failed to ensure DOH/HRLA was notified of this incident within twenty-four hours.	I 379			
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (e) Nursing:  This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure the provision of nursing services in accordance with the assessed needs of one of three residents in the sample . (Resident#2).  The findings include:  1. The GHPID nursing staff failed to obtain the results of Resident #2's colonoscopy biopsy as evidenced by:  Review of Resident #2's medical assessment dated April 25, 2011 on June 22, 2011 at	I 395			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 395	Continued From page 6  approximately 1:05 p.m., revealed the resident had a history of colon cancer. Further review of Resident #2's medical record at approximately 1:15 p.m. revealed Resident #2 was hospitalized from February 24, 2011 until March 9, 2011 with diagnoses that included constipation and C Diff. Further review revealed Resident #2 had a colonoscopy dated March 1, 2011 and had many diffuse diminutive polyps biopsied.  During a face to face interview with the Licensed Practical Nurse (LPN) on June 22, 2011 at approximately 1:25 p.m. it was acknowledged the results of Resident #2's biopsy had not been obtained by the facility at the time of the survey.  2. The GHPID nursing staff failed to inform Resident #2's primary care physician (PCP) of the recommendations made by the Audiologist as evidenced by:  Observation on June 22, 2011 at approximately 7:15 am revealed Resident #2 was sitting at the dining room table pulling on both lower earlobes.  Review of Resident #2's audiology consult dated November 11, 2010 on June 22, 2011 at approximately 11:00 a.m., revealed a recommendation for a consult for middle ear disorder and ear wax removal.  During a face to face interview with the Licensed Practical Nurse (LPN) on June 22, 2011 at approximately 12:25 p.m. it was acknowledged Resident #2's PCP was not made aware of the recommendations by the audiologist.	I 395	1. Please find attached the results from biopsy taken 3-1-11.  2. Upon review of medical record Dr. <del>Thomson</del> @ GW Univ. Hospital reported cerumen fully removed with difficulty and return in one year on 10-22-10. on 11-11-10 the Audiologist completed hearing exam and recommended cerumen removal and consultation for middle ear disorder. Ward & Ward nursing did not properly submit consultation form to PCP @ actual report thus the middle ear was not started. An ENT appt has been scheduled for 7/29/11 cerumen removal and audio 11/4/11 for middle ear disorder.	7-8-11  7-8-11	
I 397	3520.2(g) PROFESSION SERVICES: GENERAL PROVISIONS	I 397			

for 7/29/11 cerumen removal and audio 11/4/11 for middle ear disorder.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 397	Continued From page 7  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (g) Psychology;  This Statute is not met as evidenced by: Based on observation, interview, and review of medical records, the Psychiatrist failed to ensure that comprehensive functional assessments were conducted for one of three residents in the sample. (Resident #1)  The finding includes:  Resident #1 was observed in the living room on June 22, 2011 at approximately 6:45 a.m. attempting to kick at peers passing by without making physical contact. Interview with the Licensed Practical Nurse (LPN) on June 22, 2011 at approximately 10:45 a.m. revealed Resident #1 had a diagnosis of Intermittent Explosive Disorder (IED) and was prescribed Zyprexa 2.5 mg every night and Revia 50 mg twice a day. Further interview revealed Resident #1 had targeted behaviors including kicking, hand biting and non-compliance with medical appointments. Interview with the House Manager (HM) on June 22, 2011 at approximately 12:00 p.m. revealed Resident #1 had a program to document his target behaviors, however the facility did not have a Behavioral Support Plan (BSP) in his medical record	I 397	Please find attached the diagnostic assessment dated 5-20-11. The assessment recommends (Page 5) BSP update, Continued psychiatric intervention and medication administering and monitoring. We will continue to follow up with total care for the BSP update.	7-8-11	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 'S' ST, NE WASHINGTON, DC 20002</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 397	Continued From page 8  because the BSP was in the process of being updated. Review of Resident #1's medical records confirmed the aforementioned statements.  There was no documented evidence the resident had a BSP on file in the medical record.	I 397			